Start Assignment

Due Sep 24 by 10:59pm **Points** 16 **Submitting** a text entry box or a file upload
Attempts 0 **Allowed Attempts** 2

«Back to Week at a Glance (https://waldenu.instructure.com/courses/81443/modules/items/2646085)

RESEARCH CRITICAL ANALYSIS OF A JOURNAL ARTICLE

The purpose of this Assignment is to allow you to practice the critical analysis of the contents of research articles. When you identify a research article, you want to begin by assessing whether the source of the article is scholarly and current. Once you have verified these elements, it is important to determine what the researchers were attempting to investigate, how the study was carried out, and what the outcomes were.

For this Assignment, you will critically examine the elements of a scholarly article. Because you will need to choose research articles that represent each type of methodology when you create your Final Project Annotated Bibliography, it is essential for you to understand the contents of a research article.

RESOURCES

Be sure to review the Learning Resources before completing this activity.
Click the weekly resources link to access the resources.

WEEKLY RESOURCES (https://waldenu.instructure.com/courses/81443/modules/items/2646090)

To Prepare

- Review the media programs and blog found in the Learning Resources which will introduce you to the critical elements of a scholarly article, how to identify them, and how to read scholarly articles.

- Review the Haas and Ray (2020) article found in the Learning Resources. You will use this article to complete this Assignment.
- Review the **Scholarly Article Content Analysis Worksheet Preparation Guide, the Scholarly Article Content Analysis Worksheet including the brief case conceptualization found in the Learning Resources and consider** the "client" for any counseling implications. **Note: you will use this Worksheet to complete this Assignment.**

Assignment

- Complete the Scholarly Article Content Analysis Worksheet for the Hass & Ray (2020) article.
- Analyze the contents of the article and apply the findings to the case conceptualization included in the worksheet.
- Critically analyze the article and identify all components:
  - Is the article scholarly?
  - What is the problem/purpose?
  - What is(are) the research question(s)?
  - Who are the participants?
  - What are the ethical/cultural considerations?
  - What data /information was collected from participants?
  - How did the researchers describe the results/answer to the research question?
  - How does this research apply to the case study?

Be sure to support your Assignment by citing all resources including those in the Learning Resources. Use proper APA format and citations.

BY DAY 7

Submit your Scholarly Article Content Analysis Worksheet Assignment.

SUBMISSION INFORMATION

Before submitting your final assignment, you can check your draft for authenticity. To check your draft, access the **Turnitin Drafts** from the **Start Here** area.

1. To submit your completed assignment, save your Assignment as **WK4Assgn+last name+first initial.**
2. Then, click on **Start Assignment** near the top of the page.
3. Next, click on **Upload File** and select **Submit Assignment** for review.

COUN_6626F_Week4_Assignment_Rubric

Criteria	Ratings				Pts
Responsiveness: By Day 7, complete the Scholarly Article Content Analysis Worksheet for the Haas and Ray (2020) article.Analyze the contents of the article and apply the findings to the case conceptualization included in the worksheet.Critically analyze the article and identify all components:Is the article scholarly? What is the problem/purpose? What is(are) the research question(s)?Who are the participants? What are the ethical/cultural considerations?What data /information was collected from participants?How did the researchers describe the results/answer to the research question? How does this research apply to the case study?	**4 to >3.5 pts** **A (90.00% to 100.00%)** Paper is responsive to and exceeds the requirements given in the instructions. It:... 1.) Responds to assigned or selected topic;... 2.) Goes beyond what is required in some meaningful way (e.g., ideas contribute a new dimension to what we know about the topic, unearths something unanticipated, etc.)	**3.5 to >3.1 pts** **B (80.00% to 89.9%)** Paper is responsive to and meets the requirements given in the instructions. It:... 1.) Responds to the assigned or selected topic;... 2.) Addresses each point of the assignment.	**3.1 to >2.7 pts** **C (70.00% to 79.9%)** Paper is somewhat responsive to the requirements given in the instructions. It:... 1.) Somewhat misses the point of the assigned or selected topic; and/or... 2.) Addresses less than all of the points of the assignment but more than half.	**2.7 to >0 pts** **F (0% to 69.9%)** Paper is unresponsive to the requirements given in the instructions. It:... 1.) Misses the point of the assigned or selected topic; and/or... 2.) Contains little evidence that the student has read, viewed, and considered the Learning Resources in the course and that the paper topic connects in a meaningful way to the course content; and/or... 3.) Addresses less than half of the aspects of the assignment.	4 pts
Content Knowledge:The extent to which the content in the paper or writing assignment demonstrates an understanding of the important knowledge	**8 to >7.1 pts** **A (90.00% to 100.00%)** The paper demonstrates:... 1.) In-depth understanding and application of	**7.1 to >6.3 pts** **B (80.00% to 89.9%)** The paper demonstrates:... 1.) Understanding and application	**6.3 to >5.5 pts** **C (70.00% to 79.9%)** The paper demonstrates:... 1.) Minimal understanding of concepts and	**5.5 to >0 pts** **F (0% to 69.9%)** The paper demonstrates:... 1.) Lack of understanding of the concepts and issues presented	8 pts

Criteria	Ratings				Pts
the paper/assignment is intended to demonstrate.	concepts and issues presented in the course (e.g., insightful interpretations or analyses; accurate and perceptive parallels, ideas, opinions, and conclusions) showing that the student has absorbed the general principles and ideas presented and makes inferences about the concepts/issues or connects to them to other ideas;... 2.) Rich and relevant examples;... 3.) Thought-provoking ideas and interpretations, original thinking, new perspectives;... 4.) Original and critical thinking; and... 5.) Mastery and thoughtful application of knowledge and skills presented in the course.	of the concepts and issues presented in the course demonstrating that the student has absorbed the general principles and ideas presented;... 2.) Relevant examples;... 3.) Thought-provoking ideas and interpretations, some original thinking; and... 4.) Critical thinking; and... 5.) Mastery and application of knowledge and skills or strategies presented in the course.	issues presented in the course, and, although generally accurate, displays some omissions and/or errors; and/or... 2.) Few and/or irrelevant examples; and/or... 3.) Few if any thought-provoking ideas, little original thinking; and/or... 4.) "Regurgitated" knowledge rather than critical thinking;... 5.) Little mastery of skills and/or numerous errors when using the knowledge, skills or strategies presented in the course.	in the course and/or application is inaccurate and contains many omissions and/or errors; and/or... 2.) No examples or irrelevant examples; and/or... 3.) No thought-provoking ideas or original thinking; and/or... 4.) No critical thinking; and/or... 5.) Many critical errors when applying knowledge, skills, or strategies presented in the course.	
Quality of Writing:The extent to which the student communicated in a way that meets graduate level writing or communication expectations.	**4 to >3.5 pts A (90.00% to 100.00%)** Writing or communication meets graduate-level expectations. The paper:... 1.) Includes language that is clear, concise, and appropriate;... 2.) Has few, if any, errors in spelling (if written), grammar, and syntax;... 3.) Is extremely well organized, logical,	**3.5 to >3.1 pts B (80.00% to 89.9%)** Writing or communication meets graduate-level expectations. The paper:... 1.) Includes language that is clear;... 2.) Has a few errors in spelling (if written), grammar, and syntax;... 3.) Is well organized, logical, and clear;... 4.) Uses	**3.1 to >2.7 pts C (70.00% to 79.9%)** Writing or communication is somewhat below graduate-level expectations: The paper:... 1.) Includes language that is unclear and/or inappropriate; and/or... 2.) Has more than occasional errors in spelling (if written), grammar, and syntax; and/or... 3.) Is	**2.7 to >0 pts F (0% to 69.9%)** Writing or communication is well below graduate-level expectations: The paper:... 1.) Includes unclear and inappropriate language; and/or... 2.) Has many errors in spelling (if written), grammar, and syntax; and/or... 3.) Lacks organization in a way that creates confusion for the	4 pts

Criteria	Ratings				Pts
	clear, and never confuses the reader or listener;... 4.) Uses a preponderance of original language and uses direct quotes only when necessary and/or appropriate;... 5.) Provides information about a source when citing or paraphrasing it.	original language and uses direct quotes when necessary and/or appropriate;... 5.) Provides information about a source when citing or paraphrasing it.	poorly organized, is at times unclear and confusing, and has some problems with logical flow; and/or... 4.) Reflects an underuse of original language and an overuse of direct quotes and paraphrases; and/or... 5.) Sometimes lacks information about a source when citing or paraphrasing it.	reader; and/or... 4.) Contains many direct quotes from original source materials and/or consistently and poorly paraphrases rather than using original language; and/or... 5.) Lacks information about a source when citing or paraphrasing it.	
					Total Points: 16

Week 4 Scholarly Article Content Analysis

Case Conceptualization:
Orion is a 4-year-old African American child. He comes into counseling referred by his primary pediatrician. Orion has been diagnosed with an autism spectrum disorder. He has difficulty with communication, has deficits in empathizing with others' intentions, and struggles with single-mindedness. Orion's parents and preschool teacher have noticed a pervasive pattern of emotional dysregulation which includes frequent episodes of hysterical crying. Orion's parents are concerned that he is not going to be promoted to kindergarten next year if he does not improve his ability to relate positively with others and improve his ability to regulate his emotions.

Article:

Haas, S. C., & Ray, D. C. (2020, July 6). Child-Centered Play Therapy with Children Affected by Adverse Childhood Experiences: A Single-Case Design. International Journal of Play Therapy. Advance online publication. *(Can be found in Resources in Week 4.)*

1. **Is the article above a peer-reviewed, scholarly source?**

Provide your answer below and outline the steps and process you took to find the selected research article. How do you know your selected article is peer reviewed? Why is it important to use a peer-reviewed article?

Tip: Peer review is part of the editorial process an article goes through before it is published in a peer-reviewed journal. Once an article is submitted to a peer-reviewed journal, the journal editors send that article to "peers" or scholars in the field to evaluate the article. To determine if a journal is peer reviewed (also sometimes called refereed journals), try one or both steps: (a) Look up the journal in the UlrichsWeb.com (available on the A-Z Database List in the Walden Library database) and determine whether it is identified as peer reviewed. Ulrich's is a directory. It is a searchable list of periodicals (magazines, journals, newspapers, etc.). It provides information about each periodical such as publisher, scope, and whether the journal uses peer review. (b) Examine the journal's website and review the submission and editorial process for evidence of peer review.

2. **What is the (a) problem the researchers were investigating/purpose of the research and (b) research question the researchers were trying to answer? This is a 2-part question.**

Your Answer here should describe the problem the researchers were investigating/purpose of the research and include the research question the researchers were trying to answer? This is a 2-part question.

Tip: Cultural considerations are related to research procedures. Consider whether there were cultural elements that may have changed the way the study took place such as language barriers, the need for an interpreter, and whether the sample matches the population that the researchers say they are studying. The key is to consider what cultural factors are pertinent to the research question. If you say you are studying an intervention for depression, the sample needs to include persons with depression. If a study is not specific to race or gender, for example, that does not make it culturally insensitive if the research didn't set out to learn about that intervention specifically applied to race or gender.

5. Identify exactly what data was collected by the researchers in the study.

Is the data quantitative (numeric data such as scores on assessments like the Iowa Basic Skills Test (IBST) or the Beck Depression Inventory (BDI)? If there are assessment instruments used – are they numerical results or narrative results?

Is the data qualitative (for example, clinical intake interviews or a narrative behavioral observation?

Your answer (2 parts) should include information about qualitative, quantitative, or mixed methods.

Tip: The variables (e.g., substance abuse) or characteristic (e.g., geographic location) being investigated is usually found in the Introduction and Method sections (and sometimes the Abstract). For example: if a researcher is investigating an intervention for the treatment of depression. The variable may be "level of depression" and the data collected could be scores on the Beck Depression Scale. All data points represent something the researcher is trying to investigate. Data can be quantitative (like a measurement, frequency, or score that is represented by a numeral) or qualitative (data captured using written or spoken words, observations, or photos). This includes things like student academic or behavioral records, historical documents, records, or artifacts like diaries or case notes.

6. What was the outcome or the general result of the research study?

What is the answer to the research question?

Your answer here should be a 2-part answer. What was the result? What was the answer to the research question?

Tip: The Discussion section is where what the authors present how the results can be applied when working with clients or students. The authors will articulate their greatest take away from the study outcomes and what they view as most important to know to meet the needs of clients or students with similar needs.

_Preparation_Guide.pdf (https://waldenu.instructure.com/files/5289251/download?download_frd=

	insensitive if the researches didn't set out to learn about that intervention specifically applied to race or gender.
5. Data: Identify exactly what data was collected by the researchers within the study. Is the data quantitative (numeric data such as scores on assessments like the Iowa Basic Skills Test (IBST) or the Beck Depression Inventory (BDI)? Is the data qualitative (for example, clinical intake interviews or a narrative behavioral observation?	The variables or phenomenon being investigated is usually found in the introduction and method sections (and sometimes the abstract). For example: if a researcher is investigating an intervention for the treatment of depression. The variable may be "level of depression" and the data collected could be scores on the Beck Depression Scale. All data points represent something the researcher is trying to investigate. Data can be quantitative (like a measurement, frequency, or score that is represented by a numeral) or qualitative (data captured using written or spoken words, observations or photos). This includes things like student academic or behavioral records, historical documents, records, or artifacts like diaries, journals or case notes.
6. Analysis: What was the outcome/the general findings of the study? What is the answer to the research question?	The authors identify if the results of the investigation support their hypothesis and present the major findings. The Results present the answer to the question the researchers were trying to learn. Keep in mind that when you are investigating an intervention, the findings could be mixed. In other words, the intervention might be successful, not successful, or partially successful.

- Walden University, LLC. (Producer). (2017k). *Purpose of research* [Video file]. Baltimore, MD: Author.
  Note: The approximate length of this media piece is 15 minutes. This media piece is also in the resources of Week 2.

Week 4 Scholarly Article Content Analysis Preparation Guide

Please review the following information to help you prepare for the Week 4 Assignment

Components of a Research Article
Title and Author Information: The title of the article is important as it is a critical element for identifying the article when searching data bases. In professional counseling journals, the author who most substantially worked on the draft article and the underlying research becomes the first author. The others are ranked in descending order of contribution. However, in many disciplines, such as the life sciences, the last author in a group is the principle investigator—the person who supervised the work.
Abstract: a brief (approximately 120 words) summary of the entire article. It should include • the problem under investigation or the hypothesis • pertinent information on the participants • brief review of methodology • statistical analyses • results of the study/implications of the study.
Introduction: begins with a broad statement of the problem under investigation and then proceeds to narrow the focus to the specific hypothesis(es) of the study. The purpose of this section is to introduce the reader to the overall issue/problem that is being investigated and to provide a rationale for the research. In order to accomplish these tasks, the author needs to review past research on the same topic and present previous results.
Methods: provides a detailed description of how the current study was conducted. This section outlines the procedures that the researchers followed to recruit participants, collect, and analyze data. An overarching goal of empirical studies is the replication of research. It is in the Method section that authors need to specify their participants and procedures to allow others to duplicate the study. Think of this section as being an overview of the procedures that tell you the who, what, when, where and how of the research.
Results: reporting of the data. Also known as outcomes, the purpose is to describe what was found analyzing the data. In quantitative studies, it includes a description of the statistical analysis and tables and figures are often used to convey important information in an organized manner. In quantitative studies, the themes or explanations are described along with the processes used to determine these findings such as coding.
Discussion: reviews, interprets, and evaluates the results of the study in a narrative form . Discussion sections typically begin by listing the hypotheses and then stating if the results supported or contradicted the hypotheses. Next, writers usually discuss similarities and differences between the current findings and findings of previous research. Any strengths or weaknesses of the current study are also reviewed, and suggestions are made on improving the research design. Also called "findings", the discussion can include implications of the research and how the results are connected to counseling practice. Finally, a discussion section usually ends with the writer providing suggestions for future research.
References: A list of all sources used during the development or completion of the research or the interpretation of the results. It is critical to document all sources of information and all research that was referenced or used to guide the study.

Week 4 Article Analysis	
The following information is a step by step guide for completing the worksheet.	
Assignment Questions	**Tips**
1. Peer Review Is the article above a peer-reviewed, scholarly source	Peer review is part of the editorial process an article goes through before it is published in a peer-reviewed journal. Once an article is submitted to a peer-reviewed journal, the journal editors send that article to "peers" or scholars in the field to evaluate the article. To determine if a journal is peer reviewed (also sometimes called refereed journals), try one or both of these steps: • Look up the journal in the UlrichsWeb.com (available on the A-Z Database List) and determine whether it is identified as peer reviewed. • Examine the journal's website and review the submission and editorial process for evidence of peer review.
2. Problem Statement and Research Question(s). What is the (a) problem the researchers were investigating/purpose of the research and (b) research question the researchers were trying to answer?	All studies have a research question that drives the investigation (what the researchers are trying to learn). Sometimes this is formally stated while other times the reader must discover this information which can usually be found in the Abstract or the Introduction section. The Results section or the Discussion section will provide the answer(s) to the research question. Research studies can use either quantitative, qualitative or mixed methods to investigate the question. Sometimes researchers are investigating more than one intervention and so research questions may include multiple parts. Be sure to review all parts of the inquiry or use multiple questions to explain.
3. Sample/Participants Describe the sample/participants in the study (including how many participants were in the study).	Participants are also known as the *sample*. Quantitative studies generally have larger samples sizes than qualitative studies. Case studies may have one main "case" which may include a single person, a family, a group, or community. You want to describe who (e.g., demographics) and how many persons participated in the study.

4. Procedures: Did the researchers secure permission to conduct the study and/or secure informed consent from the participants? Were there any cultural concerns noted?	Informed consent is a critical part of ethical research. The procedures for informed consent are usually described in a methods section, however, not all authors specifically state the informed consent process. Cultural considerations are related to research procedures. Consider whether there were cultural elements that may have changed the way the study took place such as language barriers, the need for an interpreter, and whether the sample *matches* the population that the researchers say they are studying. The key is to consider what cultural factors are pertinent to the research question. If you say you are studying an intervention for depression, the sample needs to include persons with depression. If a study is not specific to race or gender, for example, that does not make it culturally insensitive if the researches didn't set out to learn about that intervention specifically applied to race or gender.
5. Data: Identify exactly what data was collected by the researchers within the study. Is the data quantitative (numeric data such as scores on assessments like the Iowa Basic Skills Test (IBST) or the Beck Depression Inventory (BDI)? Is the data qualitative (for example, clinical intake interviews or a narrative behavioral observation?	The variables or phenomenon being investigated is usually found in the introduction and method sections (and sometimes the abstract). For example: if a researcher is investigating an intervention for the treatment of depression. The variable may be "level of depression" and the data collected could be scores on the Beck Depression Scale. All data points represent something the researcher is trying to investigate. Data can be quantitative (like a measurement, frequency, or score that is represented by a numeral) or qualitative (data captured using written or spoken words, observations or photos). This includes things like student academic or behavioral records, historical documents, records, or artifacts like diaries, journals or case notes.
6. Analysis: What was the outcome/the general findings of the study? What is the answer to the research question?	The authors identify if the results of the investigation support their hypothesis and present the major findings. The Results present the answer to the question the researchers were trying to learn. Keep in mind that when you are investigating an intervention, the findings could be mixed. In other words, the intervention might be successful, not successful, or partially successful.

7. Results/Discussion Based on your understanding of the findings, discuss how the outcomes can be generally applied to counseling practice.	The discussion is where what the authors present how the results can be applied when working with clients or students. The authors will articulate their greatest take away is from the study outcomes and what they view as most important to know to meet the needs of clients or students with similar needs.
8. Application How does this research apply to the case study?	While there are similarities and differences between the article and the case study on the worksheet, describe how the general outcomes from the article relate to the case study. Explain your insights into how the information from the article could be useful to meet the needs of the case study. NOTE: As a counselor, what did you learn from the outcomes of the research study in the article that you could use in developing treatment goals or action plans for the child in the case study on the worksheet?

International Journal of Play Therapy

2020, Vol. 29, No. 4, 223–236
http://dx.doi.org/10.1037/pla0000135

ISSN: 1555-6824

Child-Centered Play Therapy With Children Affected by Adverse Childhood Experiences: A Single-Case Design

Sara C. Haas
Northern Arizona University

Dee C. Ray
University of North Texas

We conducted single-case research with 2 participants to explore the influence of child-centered play therapy (CCPT) on children who had 4 or more adverse childhood experiences (ACEs) and analyzed data collected from the Strength and Difficulties Questionnaire on a weekly basis and the Trauma Symptoms Checklist for Young Children at pre- and posttest. Both participants demonstrated significant improvement in total difficulties and prosocial behaviors, revealing potential therapeutic benefits for the use of CCPT with children who have 4 or more ACEs. The discussion of study results includes implications for practice, suggestions for future research, and limitations.

Keywords: child-centered play therapy, adverse childhood experiences, single-case design

Adverse childhood experiences (ACEs) can be defined as traumatic and stressful experiences occurring in childhood (Felitti et al., 1998). Categories for ACEs include physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/divorce, domestic violence, incarceration, and living in foster care (Felitti et al., 1998; Wade et al., 2016). The commonality between all of the categories is a self-report of feeling maltreated or living in household dysfunction during childhood. The Centers for Disease Control and Prevention (CDC, 2019) noted that over 50% of adults in the United States have reported experiencing at least one ACE, and 15% have reported experiencing four or more ACEs. Adverse experiences occurring in childhood have been found to have a profound influence on the health and well-being of children and adults (Clarkson Freeman, 2014; Felitti et al., 1998; Wade et al., 2016). The resulting trauma that, over multiple events, leads to complex trauma is a common outcome and response to the experiencing of adverse experiences (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Although various mental health interventions have been proposed to address the symptoms resulting from ACEs and childhood trauma, there is still little evidence to support positive treatment outcomes for children who have experienced ACEs. Child-centered play therapy (CCPT) fosters connections and relationships in a safe, therapeutic environment, lending to the potential of CCPT being an effective intervention with children who have experienced multiple ACEs.

Broad Spectrum of ACEs Outcomes

Adverse experiences occurring in childhood have been found to have a profound influence on the health and well-being of adults (Felitti et al., 1998; Wade et al., 2016). ACEs have long-term effects on physical and mental health, addictive behaviors, criminal activities, and adult relationships. As a result of ACEs, adults may

This article was published Online First July 6, 2020.
Sara C. Haas, Department of Educational Psychology, Northern Arizona University; Dee C. Ray, Department of Counseling and Higher Education, University of North Texas.

Correspondence concerning this article should be addressed to Sara C. Haas, Department of Educational Psychology, Northern Arizona University, 15451 North 28th Avenue, Phoenix, AZ 85053. E-mail: sara.haas@nau.edu

have a higher risk for health symptoms that lead to death and a shortened life span, as well as fatigue and lack of energy that impact the perceived quality of life (Felitti et al., 1998). Subsequent mental health issues, such as posttraumatic stress, depression, anxiety, hopelessness, stress, and even suicidal behavior, appear to be linked to a person's ACEs. Generally, affective disorders, as well as depressive and anxiety disorders, in adulthood are likely to be correlated with adverse experiences in childhood (Spinhoven et al., 2010). Grasso, Dierkhising, Branson, Ford, and Lee (2016) found that if children had multiple types of ACEs during any time of childhood, early childhood, middle childhood, or adolescence, the participants were affected developmentally and had a persistent amount of stress into adolescence and adulthood.

Additionally, ACEs appear to be linked to later substance abuse and criminal activity. Substance abuse issues are highly correlated with an increased number of ACEs (Felitti et al., 1998), a consistent finding across cultures (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015; Giordano, Ohlsson, Kendler, Sundquist, & Sundquist, 2014). Regarding criminal activity, researchers have linked juvenile offenders and an increased number of ACEs (Baglivio & Epps, 2016). Fox, Perez, Cass, Baglivio, and Epps (2015) found that the number of ACEs experienced by serious, violent, and chronic offenders was statistically significantly higher than the number of ACEs for offenders who had one violation, suggesting that the identification of ACEs could be one indicator in determining youth who are at a higher risk of becoming serious, violent, and chronic offenders.

ACEs Outcomes During Childhood

Although research has been conducted on the effects of ACEs in adulthood, there are substantially fewer studies exploring the effects of ACEs during childhood. Burke, Hellman, Scott, Weems, and Carrion (2011) found that children who experienced four or more ACEs had a significantly higher probability of having learning and behavior problems. Utilizing the National Survey of Child and Adolescent Well-Being (NSCAW) and the Child Behavior Checklist (CBCL; Achenbach, 1991), Clarkson Freeman (2014) examined the prevalence and relationship between ACEs and internalizing, externalizing, and total problems for 2,830 children 6 years of age and younger. Overall, children who had four or more ACEs were more likely to exhibit problematic behaviors than children who did not experience ACEs (Clarkson Freeman, 2014). Escueta, Whetten, Ostermann, O'Donnell, and the Positive Outcomes for Orphans Research Team (2014) examined the psychosocial well-being and cognitive development of orphaned and abandoned children who experienced ACEs in five low-income countries. They found that exposure to potentially traumatic events was determined to be a predictor of emotional difficulties. Child research on ACEs reveals a dose–effect response whereby the more ACEs reported, the higher the number and intensity of negative outcomes (Grasso et al., 2016; Jimenez, Wade, Lin, Morrow, & Reichman, 2016; Thurston, Bell, & Induni, 2018). Although research on ACEs while participants are still in childhood is limited, there is evidence to suggest that children exhibit the deleterious consequences of ACEs during and immediately following adverse events.

The CCPT and ACE Connection

As children grow and develop, influences from caregivers have the potential to disconnect them from their natural organismic valuing process. Although the organismic valuing process still remains, children begin to rely more on external messages from caregivers and become less attuned to their organismic valuing process, placing greater emphasis on what others value (Turner, 2012). Children's self-structure changes to integrate the way they view themselves and their actual experiences (Wilkins, 2010). Children strive to be protected, nurtured, and cared for by others. Because of the need to be positively regarded by others, children rely on an external locus of control and create conditions of worth. Conditions of worth are messages created to earn love or acceptance from others by conforming to demands, expectations, and positive evaluations from others (Wilkins, 2010). Children may begin to have beliefs of only being accepted when their conditions of worth are met. Children experience incongruity because they no longer take in all experiences through their organismic valuing process; in-

stead, experiences are taken in through the filter of a rigid self-perception influenced by the values of others (Wilkins, 2010).

Because of the nature of the conditions provided to children who have experienced ACEs, they may develop extremely negative and abusive self-regard, which can become the focus of their self-concepts and influence their decisions and attitudes toward themselves (Power, 2012). Children who experience ongoing adverse and traumatic experiences likely live in a world of fear (Hawkins, 2014). Whereas typical self-structures are fluid and allow for new experiences to help shape the way children view experiences (Rogers, 1957), the self-structures of children who have ongoing adverse or traumatic experiences are rigid (Wilkins, 2010). The rigidity of self-structure occurs because their conditions of worth continue to contribute to their negative self-regard. Children's understanding of the world and reality might be altered and viewed through a more negative lens. Ongoing confirmation of negativity serves the purpose of maintaining the rigidity of the self-structure. The utilization of negative behaviors ensures that others will treat them in ways matching their current self-concept (Clarkson Freeman, 2014).

Children who have experienced multiple or ongoing ACEs are likely to need experiences that contradict the traumatic experiences that have influenced their rigid self-structures. CCPT is an intervention that promotes the relationship between therapist and child as the primary healing agent in therapy (Landreth, 2012). Child-centered play therapists hold the belief that children innately have the capacity within them to work through and make sense of maladaptive behaviors when provided with the necessary environment (Landreth, 2012). CCPT therapists provide the core conditions of person-centered theory—congruence, empathic understanding, and unconditional positive regard (UPR)—to create a therapeutic relationship with children (Landreth, 2012). As a child slowly perceives and integrates the therapist attitudinal conditions, the child is able to form a new self-structure. When counselors are free of expectations while unconditionally positively regarding clients, children are able to grow and develop (Rogers, 1957). Although the self-actualizing tendency may have been halted through adverse events, it is still a dynamic force inside of a child. By experiencing UPR and empathic understanding, a child can begin to integrate new experiences and establish a more fluid self-structure (Ray, 2011). The fluidity of self-structure will provide the child with the ability to accept more positive experiences without rejecting them fully. In essence, CCPT offers an alternative positive childhood experience to counteract the negative impact of conditions and disrupted relationships experienced during adverse events. Additionally, CCPT involves the facilitation of parent consultation in order to address the environmental facilitation of relationships and stability for the child.

Although CCPT research has not been conducted on ACEs as a singular construct, historical and recent research on CCPT supports the use of intervention with children with individual ACEs. Intervention research has been conducted on the individual ACEs of sexual abuse, witnessing domestic violence, and refugee trauma. Kot, Landreth, and Giordano (1998) utilized intensive CCPT with children who witnessed domestic violence. The experimental group demonstrated a statistically significant increase in self-concept and a statistically significant reduction of externalizing and total behaviors. Scott, Burlingame, Starling, Porter, and Lilly (2003) conducted 7 to 13 CCPT sessions with 26 participants aged 3 to 9 years old who were sexually abused and found that whereas the child self-report results showed progress, the parent reports did not show significant changes. Scott et al. hypothesized that children began to feel different before external changes were observable by parents. Schottelkorb, Doumas, and Garcia (2012) compared the effectiveness of CCPT to trauma-focused cognitive–behavioral therapy (TF-CBT), finding that CCPT had a statistically significant impact with children who suffered from refugee trauma. CCPT research was also conducted with children living in poverty. Although poverty is not considered an ACE, Wade et al. (2016) demonstrated that living in poverty was correlated with experiencing ACEs. Bratton et al. (2013) examined the effectiveness of CCPT with 54 children enrolled at a low-income preschool and found that the CCPT group had a statistically significant decrease of disruptive behaviors, aggression, and attention problems. Bratton et al. demonstrated the effectiveness of using CCPT to reduce the problem behaviors of children in

lower-socioeconomic-status preschools. CCPT has been shown to be effective with selected individual ACEs, lending to the hypothesis that CCPT may be effective with children who have experienced multiple ACEs.

Purpose of Study

The purpose of this study was to investigate the impact of CCPT on children who have experienced four or more ACEs. Specifically, we examined the effect of CCPT on the child's emotional symptoms, interpersonal relationships, and problem behaviors. A single-case design was implemented, and data were collected throughout baseline, intervention, and follow-up phases for two children participating in CCPT. The guiding research question for this study was as follows: What is the impact of CCPT on the emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, prosocial behavior, and posttraumatic stress of children who experienced four or more ACEs?

Method

Participants

Research participants included two children recruited from a university-based counseling clinic that serves community clients located in the southwestern United States. The clinic is an instructional and training-based clinic that serves clients across the life span. The majority of clients (60%) are children under the age of 12. Child clients served through the clinic typically come from families of low socioeconomic status and low educational attainment. Participants met the following inclusion criteria: (a) between the ages of 4 and 9 years old, (b) score of 4 or higher on the Adverse Childhood Experiences Checklist, and (c) not participating in other forms of counseling over the course of the study. Four participants were initially identified for participation. However, two of the participants, who were also siblings, were dropped from the study because of home disruption during the course of the study, resulting in the completion of the study by two participants. The individual information for each participant is provided in the following sections. Pseudonyms were used to maintain confidentiality.

Participant 1

Justin is an 8-year-old White American male who resides with his biological mother, sister, and maternal grandmother. Background information was reported by Justin's mother. Justin qualified for the study because of his exposure to eight categories of ACEs: emotional abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Prior to the divorce between Justin's mother and father, Justin's mother reported that Justin witnessed the perpetration of domestic violence upon his mother by his father. Justin's father was incarcerated multiple times for drugs and violence against Justin's mother and her property. Justin's father had a history of depression and was openly suicidal in Justin's presence. Justin also verbalized negative thoughts about his self-worth and felt responsible for mediating between his parents. At intake for participation in the current study, Justin's mother reported that Justin verbalized wanting to live with his father despite his fears and often blamed his mother for his father's behavior. Justin's mother reported that Justin had difficulty regulating emotions and cried and screamed at school. She was often asked to pick him up from school because of his difficulty.

Participant 2

Megan is a 9-year-old White American female who resides with her biological father, stepmother, and multiple siblings who are stepsiblings or half-biological siblings. Background information was reported by Megan's father and stepmother. Megan qualified for the study because of her exposure to eight categories of ACEs: sexual abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Megan's biological mother and father were separated when she was an infant. Her biological mother accused her father of sexually abusing Megan, resulting in invasive medical examinations. However, there were no findings that

Megan's biological father was physically abusive. Megan's father and stepmother reported that as a young child, Megan witnessed her mother being physically abused by her mother's boyfriend. During custodial visits with her mother, Megan was often unsupervised and found with dirty clothes and diapers when picked up by her father. Megan's biological mother died from a drug overdose when Megan was 3 years old. At intake for the present study, Megan's father reported that Megan frequently expressed low self-worth and a lack of belonging in her family.

Instruments

Adverse Childhood Experiences Checklist. The original Adverse Childhood Experiences (ACE) Checklist (Felitti et al., 1998) is a 10-item checklist that assesses adults for the past experiences of ACEs. The total number of ACEs checked provides participants with their ACE numbers. Felitti et al. (1998) introduced the original ACEs adult checklist, which included items related to physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/divorce, domestic violence, and incarceration. Wade et al. (2016) modified the adult checklist to incorporate extended ACEs, including witnessing violence, felt discrimination, lack of neighborhood safety, feeling bullied, and living in foster care. The original checklists were designed for adults to answer about their childhoods. For the purposes of the present study, the ACE Checklist was modified for language in order to use present-tense language for parents to complete items regarding their children. For example, the original ACE Checklist (Felitti et al., 1998) asked, "Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?" The question was rewritten to state, "Has your child lived with anyone who is/was a problem drinker or alcoholic or had a problem with street drugs or prescription drugs?" The ACE Checklist (Cronholm et al., 2015) included the original 10 ACEs (Felitti et al., 1998) and foster care as identified by Wade et al. (2016).

Strengths and Difficulties Questionnaire. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) is a 25-item assessment completed by parents/caregivers and used to identify the behavioral problems and interpersonal strengths of children 4 to 17 years of age. The SDQ Total Difficulties score is a composite of four subscales: Emotional Symptoms, Conduct Problems, Hyperactivity and Attentional Difficulties, and Peer Relationship Problems. The Total Difficulties score can range from 0 to 40. An additional fifth subscale indicates Prosocial Behavior. Higher Total Difficulties scores have been correlated to greater psychopathology (Goodman & Goodman, 2009). Goodman (2001) reported internal consistency reliability coefficients for the scales ranging from .41 to .87, with .82 for the total parent score. The reported mean test–retest reliability for the SDQ is $r = .72$, and the mean internal consistency is $\alpha = .71$ (National Center for Child Traumatic Stress [NCTSN], 2018). For the current study, the SDQ total score was used as the weekly measurement of behaviors for the participants.

The Trauma Symptom Checklist for Young Children. The Trauma Symptoms Checklist for Young Children (TSCYC; Briere, 2005) is an assessment used to evaluate posttraumatic stress and consists of 90 questions and the following eight subscales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress—Intrusion, Posttraumatic Stress—Avoidance, Posttraumatic Stress—Arousal, Dissociation, and Sexual Concerns. The subscales result in an overall Posttraumatic Stress score (Briere, 2005). Internal-consistency alphas were reported as ranging from .73 to .86. The test–retest reliability for the TSCYC correlation coefficients ranged from .68 to .96, with a median of $r = .88$ (Briere, 2005). For the purposes of the current study, the TSCYC total score was used as a descriptive measurement of change from pre- to posttest across the duration of the study.

Procedure

Following approval by the University of North Texas Institutional Review Board (IRB), we examined the intake documentation of children ages 4 to 9 who presented to the clinic for services. Upon determination of the children having a strong probability of having experienced ACEs based on intake caretaker report, we contacted the caregivers to provide an overview of the study and inquire about interest in participation. If parents indicated interest, we

set up parent interviews in which we gained background information, gained consent to participate, and determined eligibility through the use of the ACE Checklist–modified. Of 6 children identified as potential participants, 4 met the criterion of reporting four or more ACEs. For those four children, parents/guardians completed the initial TSCYC and SDQ. Parents continued to complete the SDQ weekly for a minimum of 3 weeks to establish a baseline, during which time the participants received no treatment. Over the course of the study, two of the participants were removed from the study as a result of a disruption in the home environment. For both participants completing the study, a consistent baseline was established at 6 weeks. Once a consistent baseline was established, the treatment phase began.

During the treatment phase, participants participated in 24 play therapy sessions held biweekly for 45 min each. Occasionally, participants only engaged in one play therapy session because of participant or play therapist illness. The participants did not engage in play therapy for 2 weeks because of holiday vacations. Parents continued to complete the SDQ weekly. At the 12-session midpoint and following the 24th session, parents/guardians completed the TSCYC. After completion of the 24th session, final interviews were conducted with the caregivers to gather information about caregivers' and children's experiences of CCPT. Following the 24th session, the SDQ was completed weekly for 4 weeks during the follow-up phase, during which parents/guardians and children did not receive services.

CCPT Intervention

The CCPT intervention was facilitated by an advanced doctoral student in a counselor education doctoral program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) who completed 2.5 years of doctoral work in counseling, had 23 hr of graduate-level coursework in play therapy, had and 5 years of experience utilizing CCPT. Additionally, the counselor was a licensed professional counselor intern and certified school counselor, and she participated in weekly supervision of play therapy with a doctoral-level faculty member who is a licensed professional counselor supervisor and a registered play therapist supervisor.

Each child was scheduled to receive 45 min of individual CCPT twice a week for 12 weeks. In order to ensure treatment adherence, a rater trained in the Child-Centered Play Therapy-Research Integrity Checklist (CCPT-RIC; Ray, Purswell, Haas, & Aldrete, 2017) rated 15 min of each session using the CCPT-RIC. Fidelity adherence was 96%, exceeding recommendations by Ray et al. (2017).

For the play therapy sessions, the playroom was equipped according to Ray's (2011) *Child-Centered Play Therapy Manual*. Each room used was equipped with a video camera to provide the opportunity to check for fidelity. The rooms varied in size but were equipped with toys and materials recommended by Landreth (2012).

Parent Consultation

Typically, regular and consistent parent consultations are a part of CCPT implementation. In order to ensure consistency with CCPT, parent consultations were conducted for 30 min biweekly, in addition to the CCPT sessions. Parent consultations were conducted following every four play therapy sessions and were held at a separate time from the play sessions. Schottelkorb, Swan, and Ogawa (2015) created a child-centered parent consultation model that was used to maintain consistency for the therapist. The five components of the parent consultation model are (a) creating and maintaining the therapeutic relationship with parents, (b) demonstrating an awareness and understanding by listening and responding, (c) honoring parents as the experts on their children, (d) providing pertinent knowledge, and (e) teaching therapeutic skills. Parent consultations followed the five components of the model in order to provide parents with information about their child and the therapeutic process while teaching skills deemed necessary to help facilitate the child–parent relationship. Schottelkorb et al. (2015) suggested a session format in order to ensure the five components are met. The first parent consultation session focused on the building of the relationship and gathering a deeper understanding of the child. Each subsequent session continued with building the relationship, gaining and providing an understanding of the child,

and teaching therapeutic techniques relevant to each individual. Final parent consultation sessions consisted of the parents and therapist reporting progress and changes witnessed throughout the process (Schottelkorb et al., 2015).

Data Analysis

Using weekly data gathered from the SDQ, we used visual data analysis to examine predictable baseline patterns, data within each phase, data between each phase, and integration of data between all phases (Ray, 2015). Following the standards from the What Works Clearinghouse on single-case-design studies (Kratochwill et al., 2013), we analyzed and reported the following: (a) the level of each phase, which is the mean of each phase; (b) the trend, which is the slope of data between each phase; (c) the variability, which is the difference between the trend and individual data points; (d) the immediacy of effect, which measures how quickly there was an effect with the intervention; (e) the consideration of overlap, which compares how much one phase overlaps with another one; and (f) the consistency of data patterns across the phases (Ray, 2015). In order to find the strength of the relationship between variables, we calculated effect size using nonoverlap of all pairs (NAP; Parker & Vannest, 2009) and interpreted according to the following criteria: 0–.65, weak effect size; .66–.92, medium effect size; and .93–1.0 strong effect size (Parker & Vannest, 2009). Data from the TSCYC were used descriptively to provide further information on change over the duration of the study.

Results

Participant 1: Justin

Justin participated in 6 weeks of a nonintervention baseline phase, 13 weeks of an intervention phase where he participated in 24 play therapy sessions, and 4 weeks of a nonintervention follow-up phase. Table 1 provides the means and standard deviations for each subscale in each phase of the study. For five subscales, Emotional Symptoms, Conduct Problems, Hyperactivity and Attentional Difficulties, Peer Relationship Problems, and Total Difficulties, the means continually decreased across all phases of the study, demonstrating improvement. The means of Prosocial Behavior increased across all phases, demonstrating improvement. Figure 1 provides a graphical representation of all data. In addition to visual analysis, we calculated the NAP for Total Difficulties. Because data for individual scales can be found in Table 1, we limited our narrative results to the Total Difficulties score on the SDQ and the TSCYC.

Total Difficulties score. Level analysis of the graph indicated a decrease from a mean of 26.5 in the baseline phase to 11.69 in the treatment phase, followed by another decrease to 3 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phases of the study, with a large correlation (R^2 = .78), indicating a large relationship between the play therapy phase and Justin's decrease in overall difficulties. Analysis of variability between conditions revealed large variability between phases, with standard deviations (*SD*) of 1.22 in the baseline phase, 7.66 in the

Table 1
Means and Standard Deviations for Justin's SDQ Scores

Subscale	Baseline		Intervention		Follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*
Emotional Symptoms	7.83	.75	2	3.32	.25	.5
Conduct Problems	4.33	.52	1.77	1.17	.5	.58
Hyperactivity and Attentional Difficulties	9.67	.52	5.78	1.89	2.25	1.26
Peer Relationship Problems	4.5	.84	2.08	1.66	0	0
Prosocial Behavior	5.44	.79	7.23	1.48	9.5	1
Total Difficulties	26.5	1.22	11.69	7.60	3	.82

Note. SDQ = Strengths and Difficulties Questionnaire.

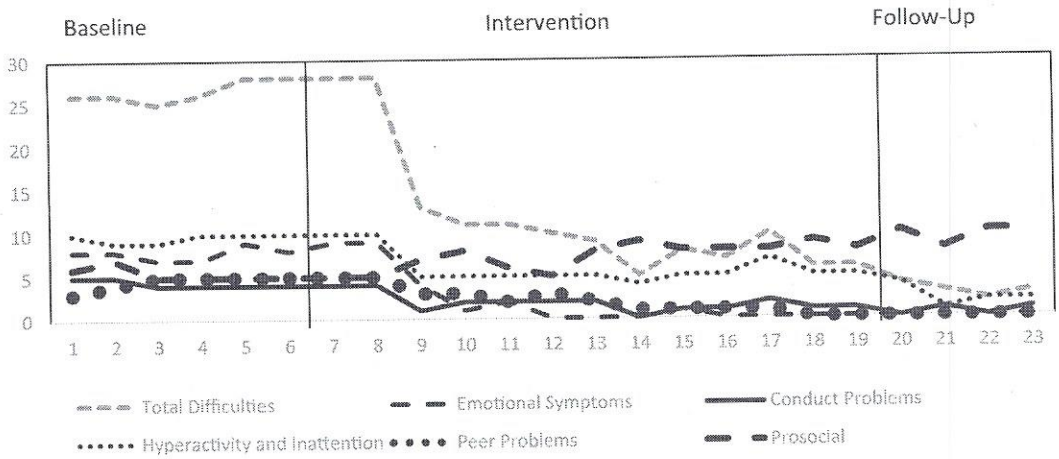

Figure 1. Justin's Strengths and Difficulties Questionnaire (SDQ) scores during baseline, intervention, and follow-up phases.

intervention phase, and .82 in the follow-up phase. The decrease was not immediate because the data did not visibly decrease until the third data point of the intervention phase. Additionally, there were overlapping data between these two phases. The mean of the last three data points in the baseline ($M = 27.33$) was similar to the mean of the first two data points in the intervention phase ($M = 28$). In addition to visual analysis, we calculated the NAP statistic to examine the degree of the treatment's effectiveness. The NAP effect size comparing the data from the baseline phase and the data from the intervention phase was a medium effect size of .87, whereas the effect-size calculation of the data from the baseline phase compared with the data from the follow-up phase was a strong effect size of 1 (Parker & Vannest, 2009).

Posttraumatic Stress score. The TSCYC was completed by Justin's mother prior to the baseline, at the 12th intervention session, and at the 24th session. The Posttraumatic Stress *T* scores were 98 prior to the intervention, 48 at the 12th session of the treatment phase, and 46 at the 24th session. The Posttraumatic Stress scores decreased over the time of the study, with substantial improvement reported after 12 sessions.

Follow-up parent interview. Upon completion of the intervention phase, Justin's mother participated in a follow-up interview. She reported that Justin demonstrated less anger and was more carefree than when the study began. He was no longer displaying sadness at school or home, and he was verbalizing his feelings and opinions. He no longer erupted in tears and anger; instead, he spoke up and shared what he was thinking and feeling. Justin's meltdowns at school stopped, and his teachers reported that he was no longer displaying problem behaviors. Justin's mother reported that he was helpful and kind at home and more readily used his manners. In regard to peer relationships, she reported that Justin had better relationships with peers and that he was able to problem solve when he was upset. Justin's mother reported positive changes to their parent–child relationship. She previously felt that Justin hated her and blamed her for the divorce, yet at the final interview, she reported feeling reconnected to him. Additionally, Justin's mother reported that he had demonstrated nurturing behaviors toward her. Overall, she reported that Justin looked forward to coming to play therapy during the intervention phase.

Participant 2: Megan

Megan participated in 6 weeks of a nonintervention baseline phase, 12 weeks of an intervention phase where she participated in 24 play therapy sessions, and 4 weeks of a nonintervention follow-up phase. Table 2 provides the means and standard deviations for each subscale in each phase of the study. For two subscales, Emotional Symptoms and Hyperactivity and

Table 2
Means and Standard Deviations for Megan's SDQ Scores

Subscale	Baseline		Intervention		Follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*
Emotional Symptoms	.83	.41	.75	.86	0	0
Conduct Problems	4.83	.75	4.83	1.33	2.25	.96
Hyperactivity and Attentional Difficulties	8.83	.98	8.25	2.01	5.25	.5
Peer Relationship Problems	1	.63	2.5	1	1.75	.95
Prosocial Behavior	8.5	.55	7.83	1.93	9.5	.58
Total Difficulties	15.5	1.64	16.18	3.59	9.25	1.71

Note. SDQ = Strengths and Difficulties Questionnaire.

Attentional Difficulties, the means continually decreased across all phases of the study, demonstrating improvement. For Conduct Problems, the means remained the same during the baseline and intervention phases and decreased during the follow-up phase. For Peer Relationship Problems and Total Difficulties, the means increased between the baseline and intervention phases and decreased during the follow-up phase. The means of Prosocial Behavior decreased between the baseline and intervention phases and increased during the follow-up phase. Figure 2 provides a graphical representation of all data.

Total Difficulties score. Level analysis of the graph indicated an increase from a mean of 15.5 in the baseline phase to 16.18 in the treatment phase, followed by a decrease to 9.25 in the follow-up phase. Trend analysis revealed a consistent trend across the baseline and treatment phases of the study, with a small correlation ($R^2 = .03$), indicating a weak relationship between the play therapy phase and Megan's decrease in overall difficulties. Analysis of variability between conditions revealed variability between phases, with standard deviations of 1.64 in the baseline phase, 3.59 in the intervention phase, and 1.71 in the follow-up phase. The decrease was not immediate because the data did not visibly decrease until the 17th data point of the intervention phase. Additionally, there were overlapping data between these two phases. The mean of the last three data points in the baseline ($M = 15.67$) was smaller than the mean of the first three data points in the intervention phase ($M = 19$). In addition to visual analysis, we calculated the NAP statistic to examine the

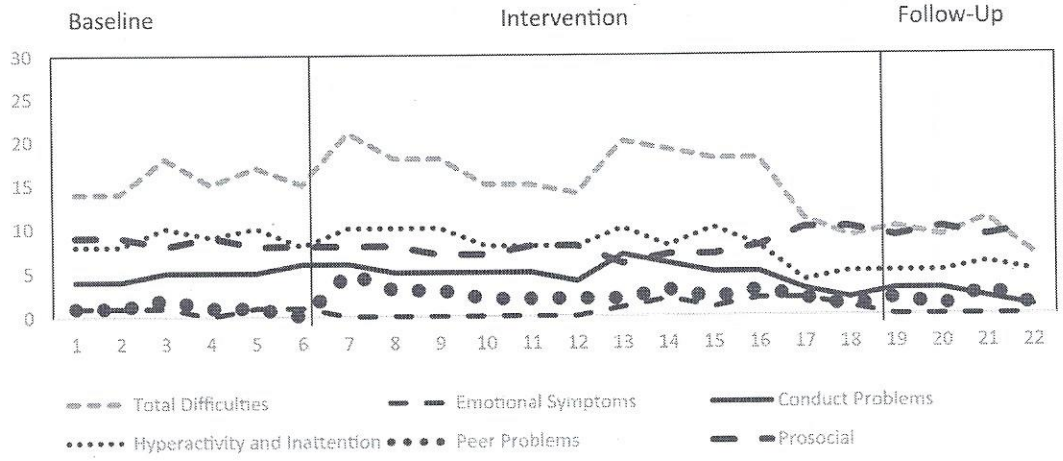

Figure 2. Megan's Strengths and Difficulties Questionnaire (SDQ) scores during baseline, intervention, and follow-up phases.

degree of the treatment's effectiveness. The NAP effect size comparing the data from the baseline phase and the data from the intervention phase was a weak effect size of −.35 in the negative direction, whereas the effect-size calculation of the data from the baseline phase compared with the data from the follow-up phase was a large effect size of 1, indicating that a substantial amount of improvement was revealed toward the end of the intervention and following the intervention.

Posttraumatic Stress score. The TSCYC was completed by Megan's stepmother prior to the baseline, at the 12fth intervention session, and at the 24th session. The Posttraumatic Stress *T* scores were 78 prior to the intervention, 76 at the 12th session of the treatment phase, and 50 at the 24h session. The Post-Traumatic Stress scores decreased over the time of the study, with the most substantial improvement occurring from the play therapy phase to follow-up.

Follow-up parent interview. Upon completion of the intervention phase, Megan's father and stepmother participated in a follow-up interview. They reported that following participation in CCPT, Megan appeared happier, bounced backed more quickly from disappointments when things did not go as planned, discussed her feelings with them, and accepted responsibilities for mistakes. They reported that Megan had a greater attention span and a better ability to stay focused at home and at school. Megan was less impulsive, and she started thinking before acting. Megan became more selective with her peer choices; therefore, she had better relationships with friends. Megan discontinued physically reacting when she was upset, and she demonstrated remorse when she was upset. They reported that Megan had become more affectionate with her stepmother, whereas prior to the study, she was only affectionate with her father. They reported having a deeper, stronger relationship and connection with Megan. Although they reported in the final interview that they initially had mixed feelings about seeking counseling, they reported that it was a positive experience. They reported that once Megan began feeling heard in the therapeutic relationship, she tried calmer ways of receiving attention at home. Through parent consultations, they discovered Megan's desire for relationships and physical touch and discontinued removing relational activities as consequences. Megan's father reported seeing gradual changes throughout the study; however, her stepmother reported that she was unaware of the gradual changes but recognized the drastic changes toward the end.

Discussion

The purpose of this study was to examine the effectiveness of facilitating CCPT with children who had four or more ACEs. Both of the participants in the study had eight ACEs, which was well over the criteria requirements for the study. Both participants demonstrated clinical levels in some or all of the subscales from the SDQ as well as high levels of posttraumatic stress at the initiation of the study. Throughout the duration of the study, both participants significantly decreased in all areas of concern and were not clinical in any area at the end of the follow-up phase. Although the improvements occurred at different times of the intervention phase, both children had lasting change once the initial change was reported. Through the play therapy experience, both participants were able to begin self-actualizing, which allowed them to build self-acceptance and self-confidence. Justin demonstrated a rapid decrease in symptomology across subscales within the intervention phase, and this continued throughout the follow-up phase. Megan's decrease in symptomology for clinically scored subscales occurred further into the intervention phase and continued throughout the follow-up phase. Although both participants decreased problematic behaviors and increased prosocial behaviors, the time in which the changes occurred was different for the participants.

Process of CCPT for Children With ACEs

Manifestation of change and growth is a slow process (Landreth, 2012). Children who lived through difficult situations typically present with intensified emotions, mostly negative and no longer tied to the reality of the moment but filtered through past experiences. When they enter therapy, their emotions are heightened, indiscriminate, and easily aroused (Moustakas, 1953). Through qualitative research, Moustakas (1953) identified four stages of change during the therapeutic process that lead to improved

functioning. As children receive faith, acceptance, and respect, relationships between therapists and children are strengthened, and children begin to move through the stages (Moustakas, 1953). Although there are significant shifts, parents and caregivers may not be immediately aware of the changes outside of the playroom.

When the conditions that created the maladjustment are still present, healing may take longer (Axline, 1947). Therapeutic relationships provide the environment for healing, but when children are still subjected to the relationships that facilitated their conditions of worth, discovering their self-worth may take longer (Axline, 1947). Therefore, if children still reside in the environment where the ACEs occurred, their maladjusted behaviors may remain persistent compared with the potential for change in a stable, nurturing environment.

In Justin's case, he still had contact with his father, but he no longer resided in the same house. Therefore, the majority of the ACEs were occurring less frequently or were less present. Justin was not exposed as often to the ongoing adverse conditions he had previously experienced. Justin's progress was identified by his mother quickly after the intervention phase began. Because many of the adverse experiences were less present, when Justin received the core conditions, his self-structure was able to adapt more quickly. His movement toward self-actualization, as evidenced through a desire to connect to others, became apparent to his mother, and she observed his self-confidence change and grow.

In Megan's case, she continued to live in an environment where some of the adverse experiences were still present. Throughout the first half of the study, Megan experienced being yelled at and ignored by her caregivers. Megan verbalized her feelings of being unwanted by her family. Therefore, the healing nature of the therapeutic relationship took longer than if those factors had been removed. As Megan strived to self-actualize during her play sessions, she was met with messages of being unwanted at home. Therefore, her self-structure remained rigid for a large portion of the session. As Megan's self-structure became more flexible, in spite of her environment, she began to demonstrate care and kindness toward her family. Megan's healing relationship with her stepmother led to alleviating some of the ACEs that were still occurring, which allowed her to continue to self-actualize. Megan's efforts to connect with her stepmother appeared to initiate her stepmother's ability to reciprocate affection and acceptance.

Implications for Practice

The results of this single-case research design have implications for clinicians who are working with children who have experienced multiple ACEs. CCPT is a promising intervention modality for working with children who have experienced multiple or ongoing ACEs. Children who have experienced multiple or ongoing ACEs might have sporadic healing experiences (Power, 2012). Children may appear to be healing when negative behaviors reoccur. Although their healing may not be a linear process, children are working through their difficulties in their own ways (Landreth, 2012). In addition, this study supported the practice of working with parents through consultation as a way to affect the child's systemic environment and encourage therapeutic progress. Yet, it also appeared that when parents were resistant to change, CCPT was effective in helping the child develop resources to provide for the parents' needs, as in the case of Megan and her stepmother, thereby affecting the parent–child relationship in a positive way.

Children who have experienced ACEs may still be exposed to the same ACEs while in play therapy. Children who have endured ongoing or multiple ACEs have had a difficult childhood prior to entering play therapy, and the nature of adversities differs based on individuals (Clarkson Freeman, 2014). Because of the varying nature of the experiences, it is difficult to predict how children will present during play therapy. Sessions with children exposed to ACEs may differ greatly. Overall, CCPT appears to be a promising intervention for children who have experienced multiple or ongoing ACEs. The results of the current study indicate that when implementing CCPT, the number of sessions with children might vary, and healing might occur quickly or gradually. Although parents may not report sudden changes, small changes may be occurring.

Implications for Research

This pilot study provided information for future research with children who have experienced multiple ACEs. Following this study, another single-case research design is suggested with a multiple-baseline design with three or more participants. By re-creating this study, using the guidelines from the What Works Clearinghouse (Kratochwill et al., 2013), researchers can assist in building the evidence-based literature for children who have experienced ACEs.

In addition to evidence-based single-case research designs, correlational research is warranted in order to explore the impact of ACEs on children during childhood. Although there are a few studies examining the correlations between ACEs and children's behaviors, more focus on children's caregiver relationships, self-concept, and emotional states would serve to increase researchers' understanding of assessment measures and the holistic effects of ACEs. Parent variables and the impact they have on therapeutic progress, as well as the number and types of ACEs children experience, are other necessary areas for inquiry. In particular, researchers might look at parents' perceived stress, attachment, and mental health concerns. The types and numbers of parent ACEs could also be correlated with the types and numbers of the children's ACEs.

To explore the generalizable effect of CCPT, we recommend randomized controlled trials in order to test the impact of CCPT for children who have experienced ACEs. Comparisons between children who have experienced multiple ACEs receiving the CCPT intervention and children who receive no treatment or alternative treatments will provide researchers a further understanding of the effects of CCPT with children who have experienced ACEs.

One observation regarding the current study is the difficulty caregivers exhibited in committing to and arranging for consistent intervention. On a therapeutic note, we recommend that play therapists provide extra, reasonable supports when possible in order to maintain the child's participation in treatment, such as convenient session times, transportation support, and flexibility with parent consultations. On a research note, we recommend that researchers recruit more participants than needed. Because of the nature of ACEs, attrition is likely to occur at a higher rate than with other studies. In addition to attrition, recruitment is difficult with this population because of the nature of the questions used to determine eligibility. Identification of children who have experienced ACEs is limited by the parent/caregiver's willingness to provide information that is sensitive and may possibly have legal repercussions.

Limitations

Because this study is the first to explore the impact of CCPT on children who have experienced multiple ACEs, there were limitations to this pilot research. The single-case design has minimal external validity, which limits the ability to generalize the findings to the general population. Although both participants demonstrated changes within the study, it is difficult to generalize these findings to all children who have experienced ACEs because of the individual nature of single-case designs. Disruptions in the home environment may have affected the way in which participants were rated by their parents. Having one rater per participant may have inhibited the researchers from gaining a deeper understanding of the effectiveness of CCPT. In order to have gained more insight, the researchers could have utilized more raters per child or incorporated an observation measure.

Because of the use of caregivers' reports regarding the occurrence of ACEs rather than the self-reports of the children who had experienced them, not all of the ACEs may have been reported. Reports were based on the parents' views of the child's experiences, and as a result of changes in home environments, parents may not have had a full understanding of the depth of the ACEs. When answering the questions, parents may not have fully grasped how their children were experiencing the environments.

Conclusion

ACEs have been shown to have negative effects throughout the life span beginning in childhood following the adverse events (Agarwal, 2015). This study demonstrated a positive impact of the use of CCPT with two children who had experienced four or more ACEs. Although each child's healing occurred at different points, both children demonstrated significant changes in symptomology. The process of

CCPT with participants who experienced ACEs appeared to support previous research related to stages of play therapy, moving from diffused negative reactions in the playroom to an integrated expression of self with positive emotions. The relationship between child and play therapist seemed to provide a reparative experience for children whose primary relationships have been made vulnerable by ACEs. Although more research is necessary, CCPT seems to demonstrate promise as an intervention for children who have experienced multiple or ongoing ACEs.

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist*. Burlington: University of Vermont, Department of Psychiatry.

Agarwal, V. (2015). Effects of adverse childhood experiences on children. *Journal of Indian Association for Child & Adolescent Mental Health, 11,* 1–6.

Axline, V. (1947). *Play therapy*. New York, NY: Ballantine Books.

Baglivio, M., & Epps, N. (2016). The interrelatedness of adverse childhood experiences among high-risk juvenile offenders. *Youth Violence and Juvenile Justice, 14,* 179–198. http://dx.doi.org/10.1177/1541204014566286

Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy, 22,* 28–42. http://dx.doi.org/10.1037/a0030318

Briere, J. (2005). *Trauma Symptom Checklist for Young Children: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Brockie, T. N., Dana-Sacco, G., Wallen, G. R., Wilcox, H. C., & Campbell, J. C. (2015). The relationship of adverse childhood experiences to PTSD, depression, poly-drug use and suicide attempt in reservation-based Native American adolescents and young adults. *American Journal of Community Psychology, 55,* 411–421. http://dx.doi.org/10.1007/s10464-015-9721-3

Burke, N. J., Hellman, J. L., Scott, B. G., Weems, C. F., & Carrion, V. G. (2011). The impact of adverse childhood experiences on an urban pediatric population. *Child Abuse & Neglect, 35,* 408–413. http://dx.doi.org/10.1016/j.chiabu.2011.02.006

Centers for Disease Control and Prevention. (2019, December 31). *Preventing adverse childhood experiences*. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html

Clarkson Freeman, P. A. (2014). Prevalence and relationship between adverse childhood experiences and child behavior among young children. *Infant Mental Health Journal, 35,* 544–554. http://dx.doi.org/10.1002/imhj.21460

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., . . . Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine, 49,* 354–361. http://dx.doi.org/10.1016/j.amepre.2015.02.001

Escueta, M., Whetten, K., Ostermann, J., O'Donnell, K., & the Positive Outcomes for Orphans Research Team. (2014). Adverse childhood experiences, psychosocial well-being and cognitive development among orphans and abandoned children in five low income countries. *BMC International Health and Human Rights, 14,* 6. http://dx.doi.org/10.1186/1472-698X-14-6

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14,* 245–258. http://dx.doi.org/10.1016/S0749-3797(98)00017-8

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect, 46,* 163–173. http://dx.doi.org/10.1016/j.chiabu.2015.01.011

Giordano, G. N., Ohlsson, H., Kendler, K. S., Sundquist, K., & Sundquist, J. (2014). Unexpected adverse childhood experiences and subsequent drug use disorder: A Swedish population study (1995–2011). *Addiction, 109,* 1119–1127. http://dx.doi.org/10.1111/add.12537

Goodman, A., & Goodman, R. (2009). Strengths and Difficulties Questionnaire as a dimensional measure of child mental health. *Journal of the American Academy of Child & Adolescent Psychiatry, 48,* 400–403. http://dx.doi.org/10.1097/CHI.0b013e3181985068

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry, 40,* 1337–1345. http://dx.doi.org/10.1097/00004583-200111000-00015

Grasso, D. J., Dierkhising, C. B., Branson, C. E., Ford, J. D., & Lee, R. (2016). Developmental patterns of adverse childhood experiences and current symptoms and impairment in youth referred

for trauma-specific services. *Journal of Abnormal Child Psychology, 44,* 871–886. http://dx.doi.org/10.1007/s10802-015-0086-8

Hawkins, J. (2014). Person-centred therapy with adult survivors of childhood sexual abuse. In P. Pearce & L. Sommerbeck (Eds.), *Person-centred practice at the difficult edge* (pp. 14–26). Monmouth, England: PCCS.

Jimenez, M. E., Wade, R., Jr., Lin, Y., Morrow, L. M., & Reichman, N. E. (2016). Adverse experiences in early childhood and kindergarten outcomes. *Pediatrics, 137,* e20151839. http://dx.doi.org/10.1542/peds.2015-1839

Kot, S., Landreth, G. L., & Giordano, M. (1998). Intensive child-centered play therapy with child witnesses of domestic violence. *International Journal of Play Therapy, 7,* 17–36. http://dx.doi.org/10.1037/h0089421

Kratochwill, T. R., Hitchcock, J. H., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M., & Shadish, W. R. (2013). Single-case intervention research design standards. *Remedial and Special Education, 34,* 26–38. http://dx.doi.org/10.1177/0741932512452794

Landreth, G. L. (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: Routledge. http://dx.doi.org/10.4324/9780203835159

Moustakas, C. E. (1953). *Children in play therapy.* New York, NY: McGraw-Hill.

National Center for Child Traumatic Stress. (2018). *Standardized measures to assess complex trauma.* Retrieved from http://www.nctsn.org/trauma-types/complex-trauma/standardized-measures-assess-complex-trauma

Parker, R. I., & Vannest, K. (2009). An improved effect size for single-case research: Nonoverlap of all pairs. *Behavior Therapy, 40,* 357–367. http://dx.doi.org/10.1016/j.beth.2008.10.006

Power, J. (2012). Person-centered therapy with adults sexually abused as children. In J. Tolan & P. Wilkins (Eds.), *Client Issues in Counselling and Psychotherapy* (pp. 47–64). New York, NY: Routledge.

Ray, D., Purswell, K., Haas, S., & Aldrete, C. (2017). Child-Centered Play Therapy-Research Integrity Checklist: Development, reliability, and use. *International Journal of Play Therapy, 26,* 207–217. http://dx.doi.org/10.1037/pla0000046

Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice.* New York, NY: Routledge. http://dx.doi.org/10.4324/9780203837269

Ray, D. C. (2015). Single-case research design and analysis: Counseling applications. *Journal of Counseling & Development, 93,* 394–402. http://dx.doi.org/10.1002/jcad.12037

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95–103. http://dx.doi.org/10.1037/h0045357

Schottelkorb, A. A., Doumas, D. M., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy, 21,* 57–73. http://dx.doi.org/10.1037/a0027430

Schottelkorb, A. A., Swan, K. L., & Ogawa, Y. (2015). Parent consultation in child-centered play therapy: A model for research and practice. *International Journal of Play Therapy, 24,* 221–233. http://dx.doi.org/10.1037/a0039609

Scott, T. A., Burlingame, G., Starling, M., Porter, C., & Lilly, J. P. (2003). Effects of individual client-centered play therapy on sexually abused children's mood, self-concept, and social competence. *International Journal of Play Therapy, 12,* 7–30. http://dx.doi.org/10.1037/h0088869

Spinhoven, P., Elzinga, B. M., Hovens, J. G., Roelofs, K., Zitman, F. G., van Oppen, P., & Penninx, B. W. (2010). The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders. *Journal of Affective Disorders, 126,* 103–112. http://dx.doi.org/10.1016/j.jad.2010.02.132

Substance Abuse and Mental Health Services Administration. (n.d.). *Shining a light on healing from childhood trauma.* Retrieved from https://blog.samhsa.gov/2018/05/09/shining-a-light-on-healing-from-childhood-trauma

Thurston, H., Bell, J. F., & Induni, M. (2018). Community-level adverse experiences and emotional regulation in children and adolescents. *Journal of Pediatric Nursing, 42,* 25–33. http://dx.doi.org/10.1016/j.pedn.2018.06.008

Turner, A. (2012). Person-centered approaches to trauma, critical incident and post-traumatic stress disorder. In J. Tolan & P. Wilkins (Eds.), *Client issues in counselling and psychotherapy* (pp. 30–46). New York, NY: Routledge.

Wade, R., Jr., Cronholm, P. F., Fein, J. A., Forke, C. M., Davis, M. B., Harkins-Schwarz, M., . . . Bair-Merritt, M. H. (2016). Household and community-level Adverse Childhood Experiences and adult health outcomes in a diverse urban population. *Child Abuse & Neglect, 52,* 135–145. http://dx.doi.org/10.1016/j.chiabu.2015.11.021

Wilkins, P. (2010). *Person-centered therapy: 100 Key Points.* London, England: Routledge.

Received March 8, 2020
Revision received May 15, 2020
Accepted May 20, 2020 ■